MDR Tracking Number: M5-04-1543-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 1-28-04.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The office visits on 2-19-03, 3-18-03, 4-18-03, 5-19-03, and 7-21-03 were **were found** to be medically necessary. The remaining office visits, manual traction, myofascial release, electrical muscle stimulation, ultrasound, therapeutic exercises, joint mobilization and chiropractic manual treatment from 1-27-03 through 8-11-03 **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 3-30-04 the Medical Review Division submitted a Notice to the requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Regarding CPT Codes 99212, 99215, 97265, 97122, 97250, 97035, 97110, 97122, and 97014 for dates of service 1-29-03, 1-31-03, 2-5-03, 2-10-03, 3-20-03, 6-13-03 and 6-16-03: Neither the insurance carrier nor the requestor submitted EOB's for these items and there is no "convincing evidence of the carrier's receipt of the provider request for an EOB" according to 133.307 (e)(2)(B)**. Recommend no reimbursement.**

CPT code 99080-73 for dates of service 2-17-03, 3-20-03 and 7-28-03 was denied with a "U" for unnecessary medical treatment, however, the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter and, therefore, recommends reimbursement. Requestor submitted relevant information to support delivery of service. Per 133.106(f)(i) **recommend reimbursement of $45.00. ($15.00 x 3).**

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003; plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 2-17-03 through 7-28-03 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 9th day of December 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

NOTICE OF INDEPENDENT REVIEW DECISION

SECOND AMENDED DECISION

Date: October 27, 2004

MDR Tracking #: M5-04-1543-01
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic physician reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

According to the supplied documentation, it appears that the claimant injured his low back while at work on ___ when he was carrying a door. The claimant reported to ___ for treatment and evaluation on 08/15/2002. The claimant began a chiropractic therapy program. The claimant had various diagnostic testing performed including but not limited to a NCV/EMG, MRI, a thoracic myelogram, a lumbar myelogram and functional capacity evaluations. The claimant was referred to and treated by ___. Several designated doctors saw the claimant. A designated doctor exam was performed on 08/21/2003 by ___ who placed the claimant at maximum medical improvement with a whole person impairment of 0%.

Requested Service(s)

Please review and address the medical necessity of the outpatient services including office visits, manual traction, myofascial release, electrical muscle stimulation, ultrasound, therapeutic exercises, joint mobilization, and chiropractic manual treatment rendered between 01/27/2003 and 08/11/2003.

Decision

I agree with the treating doctor that the office visits dated 02/19/2003, 03/18/2003, 04/18/2003, 05/19/2003 and 07/21/2003 were medically necessary. The remainder of the services rendered between 01/27/2003 and 08/11/2003 were not medically necessary.

Rationale/Basis for Decision

The dates in question are services rendered approximately 5 months post-injury. It appears that the claimant underwent an adequate amount of conservative therapy prior to 01/27/2003 when the disputed services begin. Five months of passive and active therapy would be sufficient enough to analyze if non-invasive therapy would be warranted. On a report from Dr. W dated 03/08/2003, he recommended that the chiropractic treatment should be abandoned since it was not providing enough relief to the claimant. The supplied documentation did not objectively support ongoing therapy 3 times a week on a patient from 5 months to 1 year post-injury. Continued uses of passive modalities are not supported in the documentation or are they supported in current medical protocols. Since the claimant's treating doctor would need to monitor and evaluate the claimant for progression, monthly office visits are considered reasonable and medically necessary in the treatment of the claimant's case. The remainder of the care is not considered medically necessary.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the patient, the requestor, the insurance carrier, and TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 27th day of October 2004.